dental partners of Vero Beach
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2018 Patient Information Update

We appreciate you taking the time to update your records so we can treat all of your dental needs to the best of our ability. Thank you

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name

E Mail Address: _____

Phone: Home _____ Mobile _____ Work _____

Address: _____

City _____ State_____ Zip_____

We communicate with our patients through phone, e-mail and texts. Which method would you prefer?
Check all that apply: ❑House Phone ❑Cell Phone ❑E mail ❑Text Through Cell

Medical History Update

If you have a list of your current medications we will be happy to make a copy for your chart.

Do you have any CURRENT HEALTH PROBLEMS?: _____
What Medications, Vitamins, Herbs, Supplements are you currently taking?_____
_____
Are you taking or have you taken BISPHOSPHONATES? Boniva, Fosamax Etc. ? ❑ Yes ❑ No
Do you currently use cigars, cigarettes, pipe, or chewing tobacco? ❑ Yes ❑ No

Doctors Name: _____ Phone: _____

Are you allergic to or have you reacted to any of the following? (Please check all that apply)

❑ Aspirin	❑ Sulfa	❑ Food Allergies	❑ Latex
❑ Metals	❑ Erythromycin	❑ Penicillin	❑ Novocain
❑ Codeine	❑ Nitrous Oxide	❑ Other _____	

Medical History

Indicate which of the following conditions you have or have had by checking the box. Check all that apply.

❑ Diabetes, list medication _____		❑ Non-Insulin Diabetic	❑ Insulin Dependent
❑ Blood Pressure, High	❑ Respiratory Disease	❑ Asthma	❑ COPD
❑ Blood Pressure, Low	❑ Blood Disease	❑ AIDS/HIV	❑ Shortness of Breath
❑ Mitral Valve Prolapse	❑ Dementia/Alzheimer's	❑ Bleeding Disorders	❑ Eating Disorder
❑ Back/Neck Issues	❑ Arthritis	❑ Glaucoma	❑ Pregnant
❑ Thyroid Disease	❑ Kidney Disease	❑ Liver Disease	❑ Acid Reflux
❑ Fainting	❑ Psychiatric Care	❑ Anxiety/Nervous Problems	
❑ Cancer, type/when_____		❑ Chemotherapy	❑ Radiation
❑ Hepatitis, what type? _____		❑ TB	Other: _____
❑ Artificial Joints, what type, when _____			_____
❑ Heart Problems, please describe _____			
❑ Pacemaker/Heart Surgery/ Heart Valve Replacement, what and when _____			

I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. Signature _____ Date _____